

The Children and Family Eye Doctors, a division of Proliance Surgeons
17130 Avondale Way Ste 111
Redmond, WA 98052
425-885-6600
Fax: 425-885-6580

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name _____ Date of Birth _____

Previous Name _____ SSN _____

I give permission for the following organization to release patient information as stated below.

Information to be released from:	Information to be released to:
Organization/Persons Name	Organization/Persons Name
Address	Address
Fax	Fax
Phone	Phone

Describe the type of health information that may be disclosed, i.e. patient records, tests:

Describe the purpose for which the information will be used or disclosed, i.e. continuing care, copies for own use:

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information related to such diagnosis, testing and treating.

I have the right to revoke the authorization at any point before it is processed. I understand that the information can be redisclosed by the recipient and will not longer be protected.

Signature of patient or patient's authorized representative

Date signed

Relationship or status, if signed by anyone other than patient (parent, legal guardian, personal rep, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED